MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 015911

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County: Charles
City or town: Waldorf rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Chas
City or town: Waldorf
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Emma Blanche Allen

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
~~Male~~ Female	Col	married

6.(b) Name of husband or wife: Charlie
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): apr 5 - 1874

8. AGE: Years	Months	Days	If less than one day
71	10	5	hrs. min.

9. Birthplace: Louville St Mary Co
(Town, county, and state)
10. Usual occupation: Farmer Wife
11. Industry or business:

MOTHER
12. Name: William Stone
13. Birthplace: Louville St Mary Co md

FATHER
14. Maiden name: Smallwood
15. Birthplace:

16. Informant: Charlie Allen
Address: Waldorf md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-13-47 (month) (day) (year)
Cemetery or crematory: Zion Hadley
Location: Waldorf md
18. Funeral director: Smith & Ryon
Address: Waldorf md

19. 2-12-1947 (Date rec'd by registrar) M. L. Moore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/10 1947, at 6P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 19 to 2/10 1947
and that I last saw h.. alive on 2/10 1947

Immediate cause of death	DURATION
Cerebral Apoplexy	
Due to: Cardio-Vas-	
Due to: Renal Dis	
Other conditions: = Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. L. Walker M.D.
M. D. or other
Address: Waldorf, Md Date signed: 2/11/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46th)

CERTIFICATE OF DEATH

01591

Reg. Dist. No. 100

1. PLACE OF DEATH: County: Charles; City or town: Bryantown (If outside city or town limits, write RURAL and give nearest town); How long in above place of death? 14 Days; Hospital, institution, or street address where death occurred:; How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State: Md. County: Charles; City or town: (If outside city or town limits, write RURAL and give nearest town); Street No.: (If rural, give LOCATION); 2.(a) If veteran, name war:

3.(a) FULL NAME: M. Henrietta Boarman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 21, 1871

8. AGE: Years: 75 Months: 6 Days: 12 If less than one day: hrs. min.

9. Birthplace: Bryantown Chas. Md. (Town, county, and state)

10. Usual occupation: Nursing

11. Industry or business:

FATHER — 12. Name: Dr. William D. Boarman; 13. Birthplace: Bryantown, Md.

MOTHER — 14. Maiden name: Estella Gardiner; 15. Birthplace: Chaptico, Md.

16. Informant: Mrs. Gladys E. Williams; Address: Bryantown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/6/47 (month) (day) (year)

Cemetery or crematory: St. Mary's; Location: Bryantown, Md.

18. Funeral director: Hewett & Mayo; Address: Waldorf, Md.

19. 2-5-47 (Date rec'd by registrar) 19 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-3, 1947, at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-27, 1947, to 2-3, 1947 and that I last saw h C R alive on 2-2, 1947

Immediate cause of death	DURATION
Cancer of Rectum	1-27-47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [illegible] (M.D.) M. D. or other

Address: La Plata, Md. Date signed: 2-3-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

01592

Reg. Dist. No. 1200

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Jesse Abraham Bowie

3. (b) Social Security Number:

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: M.
6.(b) Name of husband or wife: Grace R. Bowie
6.(c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): Oct. 3, 1879
8. AGE: Years: 67 Months: 4 Days: 11 If less than one day: hrs. min.
9. Birthplace: Port Tobacco Chas Co. Md. (Town, county, and state)
10. Usual occupation: Carpenter 40 yrs.
11. Industry or business:
12. FATHER Name: Wesley Bowie.
13. Birthplace: Charles Co. Md.
14. MOTHER Maiden name: Alice V. Bowie.
15. Birthplace: Charles Co. Md.
16. Informant: Mrs Grace Bowie
Address: Indian Head Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 17 47 (month) (day) (year)
Cemetery or crematory: Pines (Waldorf)
Location: Waldorf, Md.
18. Funeral director: Hunt & Pyon
Address: Waldorf Md
19. 2-17-47 (Date rec'd by registrar) 19 Julia H Piney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 14 1947, at 12 25 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1946, to Feb 14 1947
and that I last saw h... alive on Feb. 14 1947

	DURATION
Immediate cause of death: Cerebral Apoplexy	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. C. Bicknell M.D.
M. D. or other
Address: Marbury Md. Date signed: Feb. 47

1-30

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

01593

Reg. Diat. No. 102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH.
County: Charles
City or town: Grayton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Grayton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles Douglass Cobey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Cld	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth data of deceased (mo., day, yr.) Jan 24 1947

8. AGE: Years | Months | Days | If less than one day: hrs. min.
Months: 1 | Days: 18

9. Birthplace: Grayton Charles Co. Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Eugene Cobey
13. Birthplace: Pennsylvania, Md.

MOTHER
14. Maiden name: Alton Giles
15. Birthplace: San Marcus, Texas.

16. Informant: Eugene Cobey
Address: Grayton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 12 47 (month) (day) (year)
Cemetery or crematory: Oak Grove.
Location: Pennsylvania.

18. Funeral director: Eugene Cobey
Address: Grayton Md

19. 47 Feb 11 (Date rec'd by Registrar) 19 47 C. V. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 11 1947, at 3 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death — DURATION
Bronchial Pneumonia.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings at operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: George C. Bickmell M.D.
M. D. or other
Address: Waldorf Md Date signed: Feb. 11 47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

01594

CERTIFICATE OF DEATH

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Physicians Memorial
Stay in hospital or inst. (yrs., or mos., or days): 10 da.
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles.
City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Alice Permelia Cooksey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

6 (b) Name of husband ~~or wife~~: Fairfax Cooksey
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 6, 1872

8. AGE: Years: 74 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Chaptico, St. Marys, Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Columbus Silkerton
13. Birthplace: St. Mary's Co. Md.

MOTHER
14. Maiden name: Nannie Davis
15. Birthplace: St. Mary's Co. Md.

16. Informant: William F. Cooksey
Address: Spring Hill, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/5/46 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: La Plata, Md.

18. Funeral director: Hewitt & Ryon
Address: Waldorf, Md.

19. 2-5-47 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2 1947, at 4:32 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 7 1946, to February 2 1947, and that I last saw h[illegible] alive on February 2 1947.

	DURATION
Immediate cause of death: Cerebral Thrombosis - general visceral Failure.	2 weeks
Due to: Hypertensive - Arteriosclerotic Cerebrovascular Disease	4 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. Farran Barber, M.D.
M. D. or other
Address: La Plata, Md. Date signed 2/2/47

Form V. S. No. 5—50M—7-8-24

MARYLAND

CERTIFICATE OF DEATH

COMMONWEALTH OF [redacted]
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

File No. 01595

Registered No. 1050

1. PLACE OF DEATH
County of Charles
Township of
or Borough of
or City of Bryantown (No. , St., Ward)

Registration District No.
Primary Registration District No.

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

2. FULL NAME Mary Lucille Farmer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	COLORED	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) May 13 1946

7. AGE	Years	Months	Days	IF LESS than 1 day, ...hrs. or ....min.
	—	9	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Baby
(c) Name of employer

9. BIRTHPLACE (city or town) Bryantown
(State or country) Charles, Maryland

PARENTS

10. NAME OF FATHER Raymond Alvin Farmer
11. BIRTHPLACE OF FATHER (city or town) Bentsville
(State or country) Charles, Maryland
12. MAIDEN NAME OF MOTHER Mary Dorothy Sewell
13. BIRTHPLACE OF MOTHER (city or town) Hughesville
(State or country) Charles, Maryland

14. Informant Raymond Alvin Farmer father
(Address) Bryantown, Md.

15. Filed 2-13, 1947 M. C. Monroe REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 13 (Day) 1947 (Year)

17. I HEREBY CERTIFY, That I attended deceased from,
Feb 12, 1947, to , 19 ,
that I last saw h[illegible] alive on Feb 12, 1947
and that death occurred, on the date stated above, at 3:30 A.m.
The CAUSE OF DEATH* was as follows:
Pneumonia, broncho

(duration) yrs. mos. 8-10 ds.
CONTRIBUTORY (SECONDARY) Hepatitis, infectious
(duration) yrs. mos. 3-4 ds.

18. Where was disease contracted
If not at place of death?
Did an operation precede death? no Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Alfred L. Lapin, M. D.
Feb 13 1947 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL
St Marys
DATE OF BURIAL 2-13 1947

20. UNDERTAKER Elmer Wade
ADDRESS Hughesville

MARGIN RESERVED FOR BINDING

N. B.—Every item should be carefully supplied. AGE should be stated EXACTLY in PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15Fe)

CERTIFICATE OF DEATH

01596

Reg. Dist. No. 102

1. PLACE OF DEATH

County: Charles

City or town: Riverside

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Riverside

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Judy Lee Keye.

3. (b) Social Security Number

4. Sex: F | 5. Color or race: Wh | 6.(a) Single, married, widowed, or divorced: Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 9 1947

8. AGE: Years — | Months — | Days 9 | If less than one day: hrs. min.

9. Birthplace: Riverside Charles Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: William Francis Thomas.

13. Birthplace: Charles Co. Md.

MOTHER 14. Maiden name: Catherine Doris Key

15. Birthplace: Charles Co. Md

16. Informant: Laura Montgomery

Address: Grayton Md.

17. Buffalo (Burial, cremation, or removal. Which?) Date thereof Feb. 18 1947 (month) (day) (year)

Cemetery or crematory: Oak Grove

Location: Pinkside, Md.

18. Funeral director: William T. Montgomery

Address: Grayton, Md.

19. Feb 18th 1947 (Date rec'd by registrar) A. V. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 18 1947, at 5 55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death — DURATION

Angiotal Cardiac Disease.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo. C. Bickell M.D. (M.D. or other)

Address: Marbury Md Date signed: Feb 18 47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01597

Reg. Dist. No. 106

1. PLACE OF DEATH:
County: Charles
City or town: Ironsides
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Ironsides
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Susie A. Montgomery
3.(b) Social Security Number

4. Sex: Female
5. Color or race: Col.
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Joseph Montgomery
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Day. Month Not Known. (1881-?)

8. AGE: Years 65 Months — Days — If less than one day ... hrs. ... min.

9. Birthplace: Ironsides, Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: Lemuel Johnson
13. Birthplace: Charles Co. Md
MOTHER 14. Maiden name: Julia Ann Dines
15. Birthplace: Charles Co. Md
16. Informant: Lawrence Montgomery
Address: 913 Florida Ave N.W. Wash D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/11/47 (month) (day) (year)
Cemetery or crematory: Mount Hope Baptist
Location: Ironsides Md
18. Funeral director: Montgomery Bros.
Address: 913 Florida Ave N.W. Wash. D.C.
19. 2/7 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7 1947, at 7:40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 28 1947, to 2/7 1947
and that I last saw her alive on January 28 1947

Immediate cause of death	DURATION
Chronic Myocarditis	2 years.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE [signature] M.D. — M. D. or other
Address: Indian Head, Md. Date signed 2/7/47

2-35

Evidence for the change of date of birth and age is shown on G 109 4/11/47

01598

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 1000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? En route
Hospital, institution, or street address where death occurred:
En route Physicians Memorial Hospital
How long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Charles
City or town: Rogues Creek
(If outside city or town limits, write RURAL and give nearest town)
Street No.: "Huckleberry"
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Blackburn Mullikin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 24 ~~1890~~ 1891

8. AGE: Years	Months	Days	If less than one day
55	55		hrs. min.

9. Birthplace: Georgetown D.C.
(Town, county, and state)

10. Usual occupation: Farm Foreman

11. Industry or business:

FATHER 12. Name: Mckinsey

13. Birthplace: "

MOTHER 14. Maiden name: Mckinsey

15. Birthplace:

16. Informant: Edna Mullikin

Address: Papas Creek Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-26-47 (month) (day) (year)

Cemetery or crematory: Georgetown Cemetery

Location: Georgetown D C

18. Funeral director: Hulett & Rayon

Address: Waldorf Md

19. 2-23 19 47 M. L. Meade
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH: February 21, 1947 at 7:00 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~ on February 21, 1947, to ~~from~~ 19..., and that I ~~last~~ saw him ~~alive~~ on Feb. 21, 1947

Immediate cause of death	DURATION
Probably Coronary thrombosis	Minutes
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.:

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy Medical Examiner James L. MacKavanagh, M.D.
M. D. or other

Address: La Plata Md Date signed 2-21-47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

CERTIFICATE OF DEATH

01599 O

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County ..... Charles

City or town ..... Welcome

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Md. County ..... Charles

City or town ..... Welcome, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Joseph Adrian Owen

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife ..... Myrtle Owens

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1896

8. AGE: Years	Months	Days	If less than one day
50			..... hrs. ..... min.

9. Birthplace ..... Welcome, Md (Town, county, and state)

10. Usual occupation ..... Merchant

11. Industry or business .....

FATHER 12. Name ..... John W. Owens

13. Birthplace ..... Chas. Co. Md.

MOTHER 14. Maiden name ..... Mamie Welch

15. Birthplace ..... Chas. Co. Md.

16. Informant ..... Mrs. Myrtle Owens

Address ..... Welcome, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-4-47 (month) (day) (year)

Cemetery or crematory ..... Arlington National

Location ..... Arlington Va.

18. Funeral director ..... Hewett & Ryon

Address ..... Waldorf, Md.

19. ..... 19..... .....

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ..... Feb. 2, 1947, at 2:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1946 to Feb. 2, 1947

and that I last saw him alive on Feb. 1, 1947

Immediate cause of death	DURATION
Carcinoma of the head of the pancreas	6 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Carcinoma of pancreas

Date of op. 1-8-47

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE ..... John L. MacKavanagh, M.D. M. D. or other

Address ..... La Plata, Md. Date signed 2-2-47

1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

01600

Reg. Diat. No. 1011

1. PLACE OF DEATH:
County: Charles
City or town: Hill Tops
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles.
City or town: Hill Tops.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alexander Ward.

3.(b) Social Security Number

4. Sex: Male
5. Color or race: Col
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Helen Ward
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): 1873

8. AGE: Years: 76 | Months: 12 | Days: 13 | If less than one day: ... hrs. ... min.

9. Birthplace: Hill Tops Charles Co. Md
(Town, county, and state)
10. Usual occupation: Farming.
11. Industry or business:
FATHER 12. Name: Wallace Ward
13. Birthplace: Charles Co. Md
MOTHER 14. Maiden name: Unknown
15. Birthplace: "
16. Informant: Randolph Ward.
Address: Hill Tops, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2. 20. 47 (month) (day) (year)
Cemetery or crematory: Zion
Location: Hill Tops, Md
18. Funeral director: Stanley Penny
Address: Pisgah Md
19. Feb 19 1947 (Date rec'd by registrar) Mrs Bee Bowie Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 17 1947, at 9 a.m.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 16 1946 to Feb 17 1946
and that I last saw h... alive on Jan 1947

Immediate cause of death	DURATION
Old Cardiac Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Geo. C. Bickell M.D. (M. D. or other)
Address: Marlboro Md Date signed Feb 19 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-2

2-1010 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

01601

Reg. Dist. No. 100 D

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Charles
City or town: Laplata Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lina Watts ~~WATTS~~

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife: Matt Watts
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Unknown 1879

8. AGE: Years: 68? Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Chas. Co. Md (Town, county, and state)
10. Usual occupation: housework
11. Industry or business

FATHER
12. Name: unknown
13. Birthplace: "

MOTHER
14. Maiden name: Susan Lancaster
15. Birthplace: Chas. Co. Md.

16. Informant: Sherman Watts
Address: Laplata, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/11/47 (month) (day) (year)
Cemetery or crematory: Mt. Rest
Location: Laplata, Md.

18. Funeral director: Hewitt & Ryan
Address: Waldorf, Md.

19. 2-11 1947 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Febr. 8, 1947, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 1944, to Febr. 8, 1947
and that I last saw h.. alive on Febr. 5, 1947

	DURATION
Immediate cause of death: Cerebral thrombosis	2 wks
Due to: Generalized arteriosclerosis	3-4 yrs.
Due to:	
Other conditions: Chronic myocarditis with congestive Heart failure	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Jas. L. MacKavanagh, M.D. M. D. or other
Address: La Plata Md Date signed 2-8-47

1-3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-d)

CERTIFICATE OF DEATH

01602

Reg. Dist. No. 1002

1. PLACE OF DEATH:

County Charles

City or town Pomfret (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Charles

City or town Pomfret (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James A. Kinkler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 18, 1879

8. AGE: Years	Months	Days	If less than one day
67	9	26	..... hrs. ..... min.

9. Birthplace Charles County, Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Anthony Kinkler

FATHER 13. Birthplace Charles County, Maryland

MOTHER 14. Maiden name Emily Adams

MOTHER 15. Birthplace Charles County, Maryland

16. Informant Mrs. Hattie Kinkler

Address Pomfret, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-17-47 (month) (day) (year)

Cemetery or crematory St. Joseph's

Location Pomfret, Maryland

18. Funeral director Hewitt Earl Cryer

Address Waldorf, Maryland

19. 2/16 19 47 Julia H. Posey (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 19 47, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-6 19 39, to Death 19 ..... and that I last saw h.. alive on 2-14 19 47

Immediate cause of death	DURATION
Arteriosclerotic Gangrene	1942
Due to Gen. Art. Sclerosis	1937
Due to	
Other conditions Hemiplegia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D.
M. D. or other

Address La Plata, Md. Date signed 2-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35